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REHAB EQUIPMENT ASSISTIVE TECHNOLOGY ORTHOPEDIC BRACING MASTECTOMY

April 26, 2006

Department of Health and Human Services
CMS
Comments on Competitive Bidding

Marosa Surgical Industries dba Avenue Medical
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Background

I own a small DME with annual sales under 2 million dollars. Medicare billings represent about 30% of our total business. We are in process to receive accreditation in fall 2006 by ACHC. Approximately 75% of our total sales are rehab with the remainder being standard DME, no oxygen or enteral feeding.

I read through the entire proposed rule and have comments on the following areas:

E. Criteria for item selection.

I would encourage your committee to separate the wheelchair product group into manual chairs, PWC and POVs. I would not bundle these products with other products such as hospital beds/ accessories. Wheelchairs require a fitting like an orthosis. Beds do not require this level of service. I would also require, in the accreditation standard that the suppliers have accreditation for "rehab technology supplier". Both JACHO and ACHC offer this specific credentialing. I would also require that the supplier has a CRTS designation. This credential requires at least 4-5 years experience in wheelchair fittings, three independent letters of recommendation, passing RESNA exam for ATS, and maintaining 15 hours of continuing education annually. I would further require that PWC and POV require a PT or OT assessment and in-home "field assessment" to ensure that the client can operate the equipment safely in the home and that it fits in the home. This would eliminate the problem of companies that "advertise mobility" on television. An independent clinician would sign-off, in addition to the face to face visit of the physician. I think bundling these items would encourage poor fittings and reduce beneficiary compliance.

Wheelchairs/POVs represent a huge dollar amount for Medicare and your agency has been diligent in processing fraud. However I think if specific criteria were put into place there would be fewer problems with fraud.

F. Submission of Bids Under the Competitive Bidding Program.
I think that suppliers need to be within 50-100 miles of the CBA. If they are not then service and follow-up with Medicare beneficiaries will be an issue. There is significantly more follow-up and service needed for wheelchair, PWC and POVs than any other piece of equipment on your list. There should be enough accredited suppliers in a CBA to make the program cost effective.

I can see this working for enteral supplies, diabetic supplies, etc. not equipment.

3. Product categories for Bidding purposes.
Again I would make wheelchairs separate from other product categories with the above mentioned stipulations.

4. Bidding Requirements section d. capped rental.
Lump sum purchase option should be mandatory for any piece of equipment that requires "life time" use. The supplier then can maintain and bill separately for servicing the equipment. I agree that "purchase" bids should be submitted for these items.

G. Conditions for Awarding Contracts
4. Evaluation of Bid
The development of Item weight, composite bid and pivotal bid seems extremely difficult. I would think that for each item the supplier wants to bid on they would simply look at retail cost and discount the item. Evaluation, set-up and delivery time should be considered. Your methodology would be appropriate for enteral feeding, diabetic supplies, incontinence supplies etc. Single items could not be bundle priced such as a bed or a wheelchair.

I would still use the concept of median range based on the number of bids in the CBA. All suppliers have MSRP available to use for equipment. So the starting point would the same for each contracted supplier. Some suppliers may discount 20% some 30% some more.

Supplier	Item	Discount	Saving	Avg Cost
A	1000	0.2	200	800
B	1000	0.3	300	700
C	1000	0.3	300	700
D	1000	0.2	200	800
E	1000	0.5	500	500
F	1000	0.35	350	650
G	1000	0.4	400	600
H	1000	0.2	200	800
I	1000	0.4	400	600
J	1000	0.2	200	800
				695

Each supplier would submit their discounted bid. The supplier who is +/- 10% would win the bid. So supplier B,C,F,G and I would win the bid at the lump sum of $695. This addresses aggressive suppliers who will gouge and not aggressive enough suppliers who will discount too little. This still saves Medicare a significant amount of money and keeps the "playing field" even.
Small suppliers will not form networks with distinct legal identities. This would not happen.

H. Determining Single Payment Amounts for individual items

2. Rebate program- **Don't do it.** Even though it would not be permitted to advertise that suppliers are offering rebates, it would be done. Also suppliers could offer false rebates and write it off as advertising expense. Suppliers who offer bids below the average price should not be awarded the bid. Rebates would encourage suppliers to provide inferior goods and services. They would receive more referrals and ultimately the beneficiaries would suffer.

If the program is managed by the CBIC's correctly and fairly, Medicare could show savings between 20-30% which is higher than the test results from Polk County or San Antonio.

Thank you for your consideration of my comments. I can be reached for questions, Monday through Friday 9am to 5pm.

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2

May, 2006

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Department of Health and Human Services
Attention: CMS-1270-P
PO Box 8013
Baltimore MD 21244-8013

RE: Comment of CMS-1270-P Proposed Rule

ELIMINATION OF SUPPLIERS

We are a small DME company (one store) in the Midwest. After reading the complete document I'm sure that the authors have not been to a DME supplier like ours and actually seen what we do everyday. We are part of the 90% (page 148 of the document) you will eliminate. We are not a big national company that has set up shops all over the US, with nothing in them, but the standards posted and the back room full of oxygen supplies. On a daily bases if you stop at these shops, no one is there, and it is impossible to return any equipment or speak to a person about problems with equipment, or extra education of the equipment. Yes, they qualify as a supplier because they have a building, with a sign, posted hours, standards posted, but where is the service to beneficiaries, which is what CMS is saying this is all about, when no one is at the site and phone calls go to an answering machine. However, our company sees every type of patient, every day, including ostomy, diabetic, wheelchair, wound care, along with hip kits, reachers, bed pans, etc. So, who will service all of these beneficiaries with these products, and still stay in business. National companies only have respiratory in mind and will leave the small stuff to the small companies. In the trial counties has

there been a site visit to the winning bidder's locations to check all this out before we move on to the next competitive bidding step.

ACCREDITATION

We are not accredited, but for our 25 years of service we have always complied with the standards, and slowly worked on heading toward this step. We think accreditation is a good move, making everyone accountable. Our concern is who will do the accreditation that knows our industry. The big accreditation organizations, which we have investigated, are hospital orientated, and they have a whole different agenda, and offerings to their mix (ex. home health nursing). We need an agency that will understand driving 90 miles to see a patient, address the limited staff, the limited office space, and income.

BIDDING PROCESS

The bidding process is complicated for a small DME company. Why does it have to be such a mystery and confusing? We do not have one person in this company (8 people) that isn't working every minute of every day. Who would have 70 hours to do a bid and how do we justify the cost of $2200, when we can't understand the complicated bidding process to see if there is even a chance against all the large nationals, that have planted themselves everywhere.

You want quality at the lowest price, and believe me, quality will suffer. We know the cost of taking care of patients. It has been our passion for years, and we can only hope that someone will step up and look at the "big picture" of who the winners really are in this game.

Peggy Silliman

Peggy Silliman, Owner
Midwest Medical Service
Watertown, South Dakota